CHAPTER 5

Increasing participation in the Medicare Savings Programs and the low-income drug subsidy

RECOMMENDATIONS

5-1 The Secretary should increase State Health Insurance Assistance Program funding for outreach to low-income Medicare beneficiaries.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

5-2 The Congress should raise Medicare Savings Program income and asset criteria to conform to low-income drug subsidy criteria.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

5-3 The Congress should change program requirements so that the Social Security Administration screens low-income drug subsidy applicants for federal Medicare Savings Program eligibility and enrolls them if they qualify.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

CHAPTER 5

Increasing participation in the Medicare Savings Programs and the low-income drug subsidy

Chapter summary

Although programs like the Medicare Savings Programs (MSPs) and the low-income drug subsidy (LIS) provide significant financial benefits to enrollees with limited incomes, most eligible beneficiaries do not participate. There are many reasons why individuals might choose not to take advantage of these programs, but researchers have found that the main barriers to enrollment are beneficiaries' lack of knowledge of the programs and the complexity of the application processes.

Overall, Medicare beneficiaries aged 65 or over are more likely to be poor or near poor than the population under 65. They spend a larger percentage of their income on out-of-pocket health costs. Those eligible for but not enrolled in MSPs are more likely than those enrolled in MSPs to report that they did not receive needed health care because of cost.

There have been a number of campaigns to increase awareness of programs like MSPs that can help this population but the campaigns have had limited success. Initiatives have focused on increasing awareness of the programs and simplifying the eligibility and

In this chapter

- Why is the participation rate in MSPs and other programs for beneficiaries with limited incomes so low?
- Relationship between MSP and LIS
- Income and health care spending for the Medicare population
- Efforts to increase program participation
- Federalizing MSP

enrollment processes. State policymakers face mixed incentives to increase enrollment in MSPs. On the one hand, the programs improve access to care for beneficiaries with limited incomes. On the other hand, states must cope with the increased Medicaid expenditures that result from increased MSP enrollment. State officials, particularly in states that provide additional drug coverage to enrollees in Part D, may have more incentive to expand beneficiary participation in LIS because it is funded entirely by the federal government. Beneficiaries enrolled in MSPs are deemed eligible for LIS.

This chapter includes three recommendations to increase participation in programs designed to aid beneficiaries with limited incomes. They are largely based on evaluations of past programs that have achieved some success targeting and enrolling these beneficiaries.

Medicare beneficiaries, particularly those who are hard to reach, get most of their information from personal contact. Beneficiaries who qualify for MSPs need help finding out about the programs and applying for them. The National Medicare Education program provides funds for beneficiary education and counseling through the Medicare call center, the beneficiary handbook, the Medicare website, multimedia campaigns, State Health Insurance Assistance Programs (SHIPs), and community-based outreach. SHIPs are the only part of the federal program that provides personal counseling to beneficiaries, but their resources are limited. Increased funding for SHIPs, which provide this one-on-one counseling, will permit more beneficiaries to have access to programs for which they are eligible.

Recommendation 5-1

COMMISSIONER VOTES:
YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

The Secretary should increase State Health Insurance Assistance Program funding for outreach to low-income Medicare beneficiaries.

In establishing the LIS, the Congress recognized that beneficiaries with incomes below 150 percent of the poverty level and with limited assets had difficulty meeting their out-of-pocket health care costs. Federal minimum

MSP income and asset levels have not been revised since the programs were established. If MSP criteria were aligned with LIS levels, beneficiaries could apply for both programs at one time. Beneficiaries would find the process simpler and states and the federal government would realize administrative savings.

The Congress should raise Medicare Savings Program income and asset criteria to conform to low-income drug subsidy criteria.

Recommendation 5-2

COMMISSIONER VOTES:
YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

If this recommendation were adopted by the Congress, beneficiaries with incomes up to 150 percent of the poverty level would be eligible for Qualifying Individual benefits.

The Social Security Administration (SSA) is responsible for determining eligibility for LIS for those individuals who are not deemed eligible for the subsidy. Beneficiaries can apply for LIS without facing the possible stigma associated with applying for help at a state Medicaid office. If MSP and LIS eligibility were based on the same criteria, SSA could screen and enroll beneficiaries for both programs simultaneously, providing MSP access to eligible beneficiaries who have not heard of it but have heard of LIS.

The Congress should change program requirements so that the Social Security Administration screens low-income drug subsidy applicants for federal Medicare Savings Program eligibility and enrolls them if they qualify.

Recommendation 5-3

COMMISSIONER VOTES:
YES 16 • NO 0 • NOT VOTING 0 • ABSENT 1

Having the federal government assume the full costs of care for individuals dually eligible for Medicare and Medicaid, as it has under the LIS program, may be the most efficient policy approach. Individuals participating in MSP programs are Medicare beneficiaries receiving assistance with Medicare costs. States vary in the way they determine eligibility and payment. However, to federalize MSP, policymakers would have to answer a number

of design questions, each involving significant trade-offs: Which of the eligibility groups that receive MSP benefits would be covered by full federal funding? What set of rules would govern program eligibility—a national standard or a higher level chosen by the state? Would Medicare assume all coinsurance for Qualified Medicare Beneficiaries? Given the potential high cost of federalizing MSPs, would states be required to maintain a level of effort? ■

Beginning with the Qualified Medicare Beneficiary (QMB) program in 1988, the Congress has created a number of programs to help beneficiaries with limited incomes pay for Medicare premiums and cost sharing. Most recently, the Congress designed a low-income drug subsidy (LIS) to augment the Medicare drug benefit for individuals with limited incomes. Although these programs provide significant financial benefits to enrollees, most eligible beneficiaries do not participate. There are many reasons why individuals might not take advantage of these programs, but researchers have found that the main barriers to enrollment are beneficiaries' lack of knowledge of the programs and the complexity of the application and enrollment processes.

In this paper, we discuss income and health spending for the Medicare Savings Program (MSP)-eligible population. Overall, Medicare beneficiaries aged 65 or over are more likely to be poor or near poor than the general population under 65. They spend a larger percentage of their income on out-of-pocket health costs. In addition, disabled beneficiaries are twice as likely to have incomes below the poverty level as the population aged 65 or older. Those beneficiaries eligible for but not enrolled in MSPs are more likely than those enrolled in MSPs to report that they did not receive needed health care because of cost.

The Commission recognizes that Medicare beneficiaries with limited incomes may have difficulty paying Medicare premiums and cost sharing. Some believe that payments to Medicare Advantage (MA) plans that exceed the cost of furnishing services to the same population under fee-for-service (FFS) Medicare are a way of providing extra help for these beneficiaries. Low-income beneficiaries are more likely to enroll in MA plans and a reduction in government payments, as the Commission has recommended, would likely affect their benefits. While some of the MA payments above FFS expenditures are used to finance extra benefits for MA enrollees, all beneficiaries, through their Part B premium, are paying for these benefits. Furthermore, these benefits do not go only to low-income beneficiaries; all MA enrollees receive the same level of benefits. The Commission argues that direct assistance provided through MSP and LIS is a more targeted and efficient way to provide this help than with overpayments to MA plans (MedPAC 2007).

The federal government, some states, and private foundations have initiated campaigns to increase awareness of MSPs, simplify the application and enrollment process, and provide assistance to individuals seeking to apply for help. These campaigns have had limited success. State policymakers face mixed incentives to increase enrollment in MSPs. On the one hand, the programs improve access to care for beneficiaries with limited incomes. On the other hand, states must cope with rising Medicaid expenditures as the programs expand. State officials, particularly in states that provide wraparound drug coverage to enrollees in Part D, may have more incentive to expand beneficiary participation in LIS, which is funded entirely by the federal government. Beneficiaries enrolled in MSP programs are deemed eligible for LIS, so states may facilitate MSP participation to increase LIS enrollment.

In this chapter we will:

- present data on income and out-of-pocket health care costs for Medicare beneficiaries,
- compare differences in health care utilization between MSP enrollees and beneficiaries who are eligible but not enrolled,
- present information on best practices to increase MSP participation,
- present recommendations designed to increase participation in these programs, and
- discuss issues related to federalizing MSPs.

Why is the participation rate in MSPs and other programs for beneficiaries with limited incomes so low?

While all beneficiaries have many decisions to make when they enroll in Medicare, those with limited incomes need more information if they are to take advantage of the help available to defray some of the costs for medical care. MSPs (including QMB, Specified Low-income Medicare Beneficiary (SLMB), and Qualifying Individual (QI)) can reduce the financial burden and thereby improve access to needed medical services for beneficiaries with limited incomes. Beneficiaries who meet income and resource (or asset) criteria pay no Medicare Part B premiums and, in some cases, no deductibles or coinsurance for Medicare-covered services (Table 5-1, p. 312). They are also deemed eligible for LIS under Part D. Despite the benefits available, participation in the programs has been low. An estimated 33 percent of eligible beneficiaries are enrolled

TABLE 5–1

Federal eligibility criteria for Medicare Savings Programs

Medicare Savings Program	Income	Asset limit (individual/couple)	Covered costs and services
QMB	<100% of poverty	$4,000/$6,000	Medicare premiums and cost-sharing
SLMB	100–120% of poverty	$4,000/$6,000	Medicare premiums
QI–block grant funded by federal government	120–135% of poverty	$4,000/$6,000	Medicare premiums

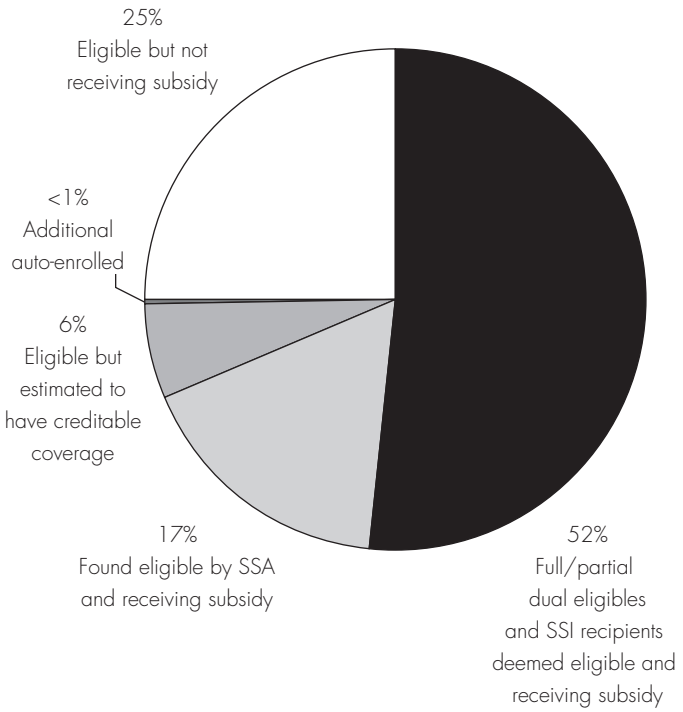
Note: QMB (Qualified Medicare Beneficiary), SLMB (Specified Low-income Medicare Beneficiary), QI (Qualifying Individual). States have the flexibility to adjust countable income and assets.

in the QMB program and fewer eligible beneficiaries (13 percent) are taking part in the SLMB program.

For MSPs, researchers have found that lack of awareness of the programs and the complexity of the application process are the main barriers qualified beneficiaries face (Haber et al. 2003).

FIGURE 5–1

Most beneficiaries receiving the low-income drug subsidy were deemed eligible



Note: SSI (Supplemental Security Income), SSA (Social Security Administration). Auto-enrolled refers to beneficiaries randomly assigned to prescription drug plans meeting the benchmarks. Creditable coverage is equivalent or more comprehensive than Part D coverage. Total may not add to 100 percent due to rounding.

Source: Kaiser Family Foundation analysis of Department of Health and Human Services data, January 30, 2007.

In one survey, analysts found that 79 percent of eligible nonenrollees had never heard of the program. Even some state Medicaid workers and other outreach counselors did not know about it (Haber et al. 2003).

Additional reasons researchers identified for low participation rates in these programs include:

- The eligible population is hard to reach because of age, linguistic barriers, isolated location, or cognitive impairment.
- Some beneficiaries are reluctant to go to a state Medicaid office because of perceived welfare stigma. Many state Medicaid offices have limited resources to seek out eligible beneficiaries.
- Beneficiaries find the application process too complex. Haber and colleagues (2003) found that two-thirds of MSP enrollees needed help applying for assistance.
- Beneficiaries are concerned that the state will try to recover expenses spent on MSP benefits after they are deceased, even though states generally do not do this for MSP-only enrollees.
- Beneficiaries have difficulty quantifying their resources (e.g., the cash value of a life insurance policy) and producing documentation.[1]

Some researchers have studied how MSP enrollees differ from other eligible beneficiaries who have not enrolled in the program. Beneficiary advocates suggest that eligible nonenrollees are more likely to be homebound, live in isolated rural communities, and have little interaction with medical institutions. For example, Cusick and Nibali (2005) noted that hospital admission often leads to MSP enrollment. Hospitals have an incentive to enroll patients to increase possible sources of payment for their services.

TABLE 5–2 **Eligibility criteria for low-income drug subsidy, 2008**

Beneficiary category	Income	Asset limit (individual/couple)	Covered costs and copayments
Full benefit dual eligibles	Deemed eligible	Deemed eligible	No premium No deductible $1.05 generic, $3.10 brand copays No copays after drug spending reaches $4,050 No copays if institutionalized
QMB, SLMB, QI	Deemed eligible	Deemed eligible	No premium No deductible $2.25 generic, $5.60 brand copays No copays after drug spending reaches $4,050
Other beneficiaries	<135% of poverty	$7,790/$12,440	No premium No deductible $2.25 generic, $5.60 brand copays No copays after drug spending reaches $4,050
Other beneficiaries	<150% of poverty	$11,990/$23,970	Sliding scale (25–100% of low-income benchmark premium) $53 deductible Assigned copay or 15% of drug costs (whichever is lower) $2.25 generic, $5.60 brand copays after drug spending reaches $4,050

Note: QMB (Qualified Medicare Beneficiary), SLMB (Specified Low-income Medicare Beneficiary), QI (Qualifying Individual). States have the flexibility to adjust countable income and assets.

For Medicare Part D, LIS limits copayments and provides coverage in the standard benefit's coverage gap for beneficiaries who meet eligibility requirements. Despite considerable publicity, participation in LIS remains limited. As of January 2007, about 9.5 million beneficiaries were receiving the drug subsidy. Of these, about 7 million, or 57 percent, of the eligible population were dual eligibles who were deemed eligible because of their Medicaid status. Another 2.3 million, or 17 percent, of the eligible population individually applied for LIS and were found eligible by the Social Security Administration (SSA) (Figure 5-1). Of those beneficiaries not automatically enrolled in LIS, the National Council on Aging estimates that between 35 percent and 42 percent of those eligible have enrolled (ABC 2007).[2] CMS estimates that most Medicare beneficiaries who have not signed up for Part D and do not have other creditable drug coverage are eligible for LIS.

Beneficiary advocates suggest that the resource test is a barrier to enrollment in both MSP and LIS. The federal MSP resource limits have not changed since 1989 when the first program (QMB) was implemented. As a result, an increasing number of people meet the income threshold but fail the asset test. For example, a beneficiary with a life insurance policy with a cash value greater than $1,500 would not be eligible. Although the resource limit is higher for LIS eligibility, SSA reported that 57 percent of those turned down for LIS would have qualified based on income, but their assets exceeded the eligibility standards.[3] Bank accounts were the most common source of additional assets (Wu 2005).

Relationship between MSP and LIS

When the Congress established the Medicare prescription drug benefit, it included additional benefits and protections for dual eligibles and other beneficiaries with limited incomes. Qualified beneficiaries pay no premiums, have limited cost sharing, and have no gap in their coverage. The Congress set income and asset criteria for LIS at higher levels than for MSP, making it easier to qualify for LIS. Table 5-2 lists the eligibility criteria and benefits

for LIS. Individuals may have assets valued as high as $11,990 and still qualify for LIS.[4] In addition, dual eligibles and those enrolled in MSPs are deemed eligible for LIS and do not have to apply. If these beneficiaries do not choose a drug plan, CMS will randomly assign them to a Part D plan with premiums at or below the low-income benchmark. Other beneficiaries may apply for the LIS subsidy at Social Security offices and do not have to go to state Medicaid offices, a perceived source of stigma to some.

Beneficiaries may apply for LIS through SSA or their state Medicaid office. To date, almost all beneficiaries who have applied for LIS have done so through SSA. However, some beneficiaries might have more success applying for LIS through their state Medicaid program. There is one national set of criteria for LIS, but each state can adjust MSP criteria according to its needs, although a state cannot set conditions more stringent than federal standards. Federal minimum criteria for MSPs are more restrictive than those for the drug subsidy, but, as noted, states are allowed to have more liberal MSP eligibility standards than federal minimum requirements. Thus, individual state MSP criteria may be less restrictive than LIS. In these states, those who qualify for MSP are deemed eligible for LIS. They do not have to demonstrate that they meet LIS income and asset standards. As a result, beneficiaries with similar incomes and assets can qualify for LIS in some states but not others. For example, Maine allows beneficiaries with incomes at or below 150 percent, 170 percent, and 185 percent of the federal poverty level to qualify for the QMB, SLMB, and QI programs, respectively (see text box).

Administrative requirements for state Medicaid workers are also different from those that apply to SSA employees. If beneficiaries apply for LIS at a Medicaid office, state employees are required to screen them for MSP eligibility. SSA employees do not have this responsibility. Some policymakers have recommended that SSA workers also be required to screen applicants for MSP eligibility.

Income and health care spending for the Medicare population

While MSP enrollment is low, the incomes and out-of-pocket health care expenditures of the elderly Medicare-eligible population suggest that the programs could fill a need for beneficiaries with limited income. In general, Medicare beneficiaries have lower incomes than individuals under age 65 and they are more likely to be poor or near poor. The median income of an individual aged 65 or over in 2006 was $17,045, compared with $28,077 for an individual younger than 65, a difference of $11,032. The income distributions of individuals aged 65 or older and those under 65 years of age also differ considerably (not shown). Roughly 35 percent of the population aged 65 or older have an annual income between $10,000 and $19,999, compared with slightly more than 15 percent of their younger counterparts. In 2006, the poverty threshold was $9,669 for an individual aged 65 or older. Thus, more of the aged are near poor than their younger counterparts.

The income disparity is more pronounced between the population aged 65 or older and the population between the ages of 55 and 64. At $31,895, the median income of an individual aged 55 to 64 was $14,850 greater than the median income of an individual aged 65 or older. Like the entire under-65 population, the income distributions of individuals aged 55 to 64 and individuals aged 65 or older also differ considerably (Figure 5-3, p. 318). Roughly 30 percent of individuals aged 55 to 64 with an income fall within the lowest two income brackets, compared with almost 60 percent of individuals aged 65 or older who have similar incomes.

Older individuals tend to have lower incomes than their younger counterparts (Figure 5-4, p. 319). More than 40 percent of the Medicare population aged 75 or older have annual incomes between $10,000 and $19,999, while 30 percent of the population aged 65 to 74 fall within this income bracket. Individuals aged 75 or older have a median income almost $5,000 less than that of individuals aged 65 to 69 (not shown). This difference is due in part to the predominance of nonmarried women in the older age bracket.

It is difficult to accurately assess the cost of living for the elderly and the sufficiency of their income. On the one hand, the cost of living for the elderly may rise faster than the cost of living for the nonelderly because of greater medical expenditures. However, the elderly are less likely to have the kinds of financial obligations that younger individuals have, such as home mortgages.

Differences in household composition and variations among survey instruments complicate comparisons of individual income and health care spending between the under-65 and 65-or-older populations. We use the Current Population Survey as our measure of median individual

Medicare Savings Program expansion in Maine

Maine is one of a number of states that initiated policies in 2006 and 2007 to increase enrollment in Medicare Savings Programs (MSPs). Commission staff, with the help of contractors from Georgetown University and NORC, conducted a site visit in July 2007 to discuss policy changes with state officials, beneficiary counselors, advocates, beneficiaries, and providers.

In 2007, Maine broadened the Medicare Savings Programs' eligibility criteria. On January 1, the state instituted a policy to disregard all assets—effectively eliminating the asset test for the programs. Higher income eligibility limits for the Medicare savings programs became effective in April 2007. The new limits are at or below 150 percent, 170 percent, and 185 percent of the federal poverty level for the Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs, respectively. These are significantly higher than current federal limits, which are 100 percent, 120 percent, and 135 percent of the federal poverty level for the programs. Maine's policymakers set the QI income eligibility limit at a level corresponding to the income limits for the State Pharmacy Assistance Program called "the low-cost Drugs for the Elderly and Disabled Program" (DEL). With the new eligibility rules in effect, the state deemed all DEL enrollees eligible for MSPs.

In broadening the eligibility criteria for MSPs, the state effectively expanded LIS eligibility criteria for Maine residents and increased the number of beneficiaries eligible for the drug subsidy. Since the federal government subsidizes Part D premiums and cost sharing for Medicare beneficiaries who qualify for LIS, officials in Maine reasoned that the state could achieve some savings as larger numbers of individuals enrolled in DEL became eligible for LIS. They anticipated that savings could then be used to provide wraparound benefits for DEL enrollees.

As anticipated, enrollment in MSP increased substantially in Maine—from almost 9,000 enrollees in January 2006 to more than 30,000 in July 2007. The largest increase occurred in April 2007 when the new income limits went into effect and the state deemed DEL enrollees eligible for MSPs.[5] Approximately 13,500 beneficiaries were added to the MSP rolls that month.

Within the MSPs, a dramatic shift occurred as SLMB and QI enrollees became eligible for the QMB program. Officials found that, because the new income eligibility limit of 150 percent of the federal poverty level for the QMB program is higher than the former highest limit for both the SLMB and QI programs, all previous MSP participants became QMB participants (Figure 5-2, p. 316).[6]

With the shift of so many enrollees to the QMB program, the federal government now covers a substantial portion of the cost of providing drugs under DEL, leaving state funds available, which can be redirected to provide other benefits for DEL enrollees. At the same time, however, the shift to the QMB program meant that the state Medicaid program took on a significant new financial responsibility. The state must now subsidize Medicare premiums for about 4,000 enrollees whose status changed from QI to QMB.[7] In addition, the QMB program covers Medicare deductibles and cost sharing as well as premiums.

Figures are not yet available for the cost of this change in terms of new Medicaid spending. Spending for Medicare premiums and deductibles is fairly predictable. The outstanding question is how costly payments for Medicare services for the new QMBs will be as the state assumes responsibility for Medicare cost sharing. Officials anticipate that the cost will be modest.

When Medicaid coverage wraps around Medicare coverage of a service, Medicare pays providers according to its payment methods and costs. In theory, Medicaid pays the associated cost sharing. However, state Medicaid programs are not required to pay the full cost-sharing amount so long as their payment policies are written in their state plan. States are free to cap their liability so that providers receive no more than the state

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Medicare Savings Program expansion in Maine (continued)

would have paid if the beneficiary had only Medicaid. Because so many states' Medicaid payment rates are lower than the total Medicare payment rates (program payments plus coinsurance), and often below the program payment alone, providers caring for QMBs (or dual eligibles in general) frequently do not receive the full coinsurance. This is the case in Maine. In general, the provider cannot bill the beneficiary for any portion of the coinsurance unless the state permits providers to charge a nominal copayment for the service.

In our interviews with state officials, counselors, and advocates, we were told that MSP enrollment increased for reasons other than the deeming of DEL enrollees. Although opinions differed, advocates told us that the publicity surrounding the Part D program and the efforts to reach and enroll beneficiaries in LIS led to increased enrollment in MSPs. They note that people do not know what the MSPs are called, but now they know about the programs, owing in great part to publicity related to Part D. The state has a strong tradition of collaboration among state agencies and community organizations that work with the elderly and individuals with disabilities, so there was a concerted effort to publicize other programs for low-income Medicare beneficiaries along with the Part D LIS.

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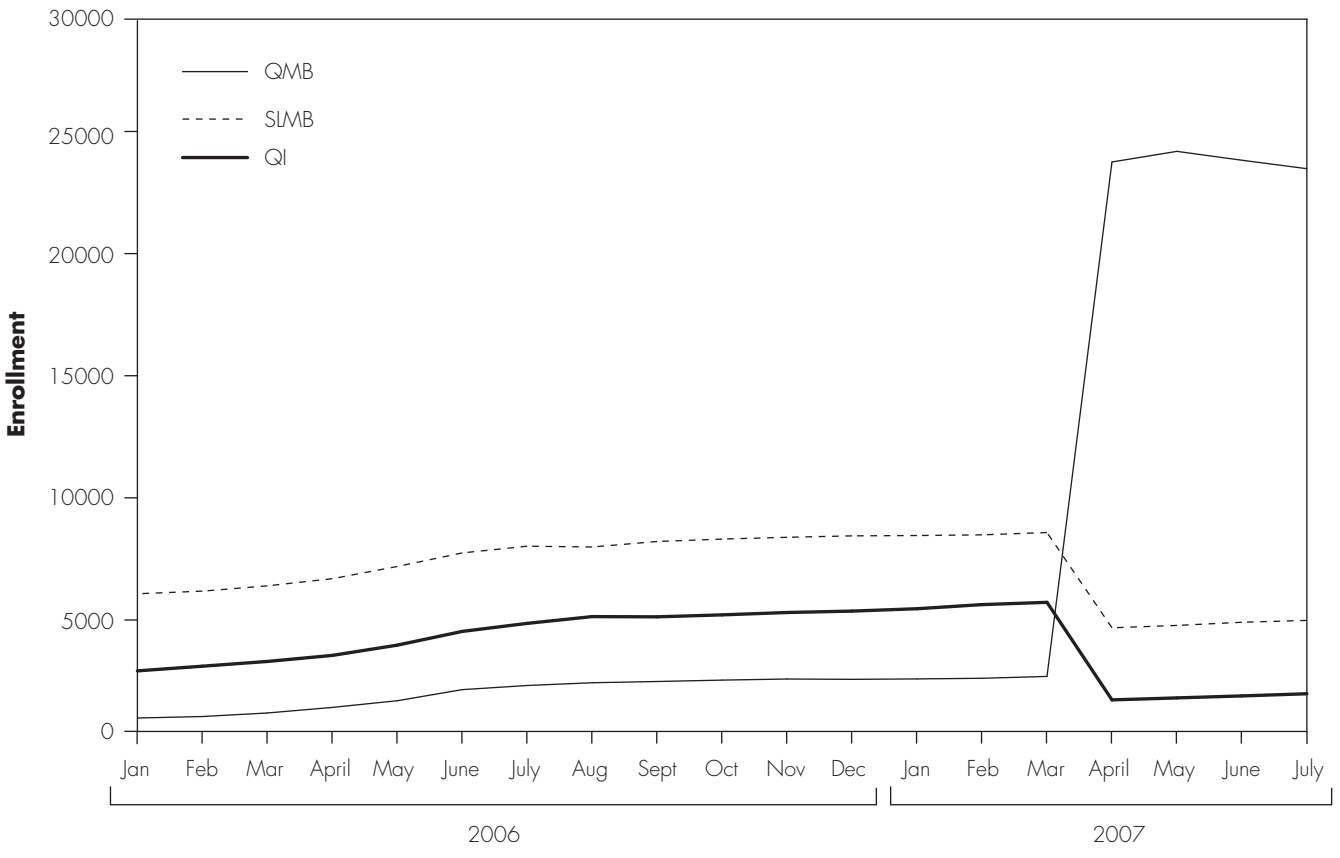
FIGURE 5–2

Maine has moved many of its residents into Medicare Savings Programs with more benefits



Note: QMB (Qualified Medicare Beneficiary), SLMB (Specified Low-income Medicare Beneficiary), QI (Qualifying Individual).

Source: Data provided by Maine Department of Health and Human Services, July 2007.

Medicare Savings Program expansion in Maine (continued)

Beneficiary counselors report that people's pride and a wariness of government programs have been barriers to program participation in Maine. Thus, advocates developed outreach messages for LIS and MSPs that presented them as providing opportunities to save money, rather than as a source of help. Counselors note that, as more people participate, the programs become more accepted in the community.

The sense among officials, counselors, and advocates is that individuals who do not know about the program are those who are most isolated. They may be homebound or live in very rural areas. In addition, respondents reported that the newly disabled as well as individuals with mental health problems or cognitive disabilities have low participation rates.

Counselors in Maine reported that concerns about estate recovery are common among the older population.[8] Although individuals who participate in MSPs are not subject to estate recovery (as they are if they participate in the full Medicaid program), one application, which includes language about estate recovery, is used for all programs. Therefore, counselors say they spend a great deal of time explaining that estate recovery rules do not apply to MSPs. Counselors also report that, although applications are fairly straightforward, their clients still have difficulty completing them. The same application is used for all applicants and information about assets is still required, even though they are no longer counted in determining MSP eligibility. Respondents articulated two reasons for this practice. First, officials are concerned that if information on assets is not collected, beneficiaries may not report income from assets. Second, counselors need asset information to screen applicants for eligibility for other relevant programs.

Finally, we found that enrollment may be affected by the annual eligibility review required for MSPs. Counselors report that they commonly help beneficiaries re-enroll in the programs because they have failed to respond to the letters they receive about their eligibility reviews; beneficiaries find the letters confusing and do not realize they have to return them to keep their benefits. A recent small decline in MSP enrollment may reflect difficulties related to the review process. ■

income because it provides the most recent data. Data on sources of income for the 65-or-older population are reported for married couples and nonmarried persons. The data we present on out-of-pocket health care spending are from the Consumer Expenditure Survey, which uses the consumer unit (CU) as the unit of analysis. This refers to related individuals living together, individuals living alone or with others but keeping separate finances, or unrelated persons living together and pooling income and expenditures. CUs can consist of one or more people, but we restrict ourselves to comparing out-of-pocket spending between one-person CUs aged 65 or older and one-person CUs under 65 years of age to facilitate comparisons on an individual basis.

Sources of beneficiary income

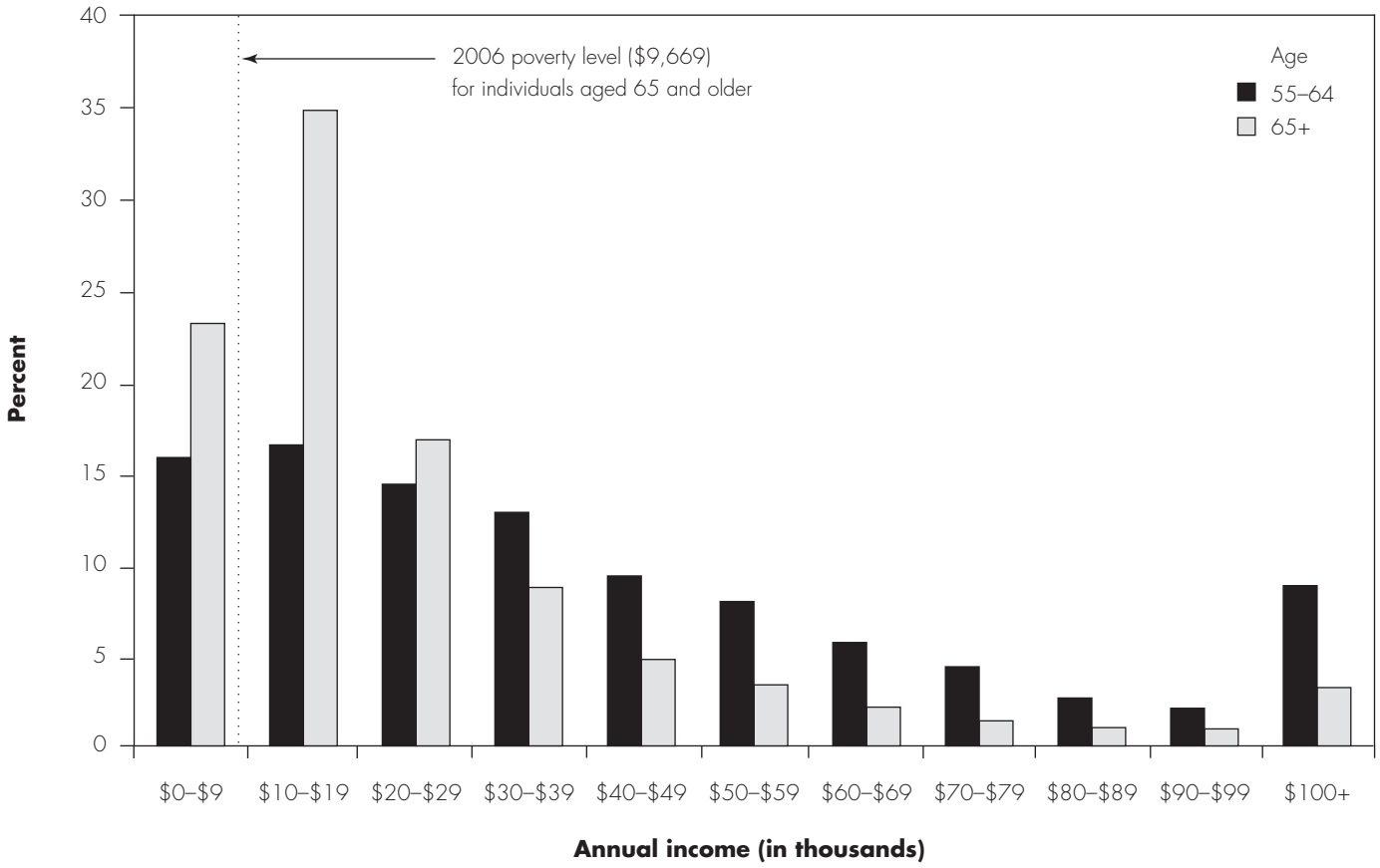
Medicare beneficiaries are most likely to rely on Social Security as their major source of income (Figure 5-5, p. 320). In 2004, 89 percent of individuals aged 65 or older received income from Social Security; 55 percent received income from assets; 41 percent received retirement benefits other than Social Security; 24 percent received income from earnings; 4 percent received public assistance; and 4 percent received veterans' benefits.

While reliable asset data are not available, data on income derived from assets show that most beneficiaries receive little income from this source. Beneficiaries receive most asset income from interest earned on personal savings (dividends and rent also fall within this category). More than half of individuals aged 65 or older collected income from assets in 2003 but the median interest earned from personal savings was $438, suggesting that assets do not provide a large source of income.

Medicare beneficiaries with higher incomes were more likely to have income from assets. Nearly 82 percent of individuals aged 65 or older in the highest income

FIGURE 5–3

Older people tend to have lower incomes



Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement.

quintile had income from assets, while only 34 percent of individuals aged 65 or older in the lowest income quintile had such income. Median income from assets in the highest income quintile was $4,384, compared with the median asset income of $200 in the lowest income quintile.

Median income and income distribution among the disabled

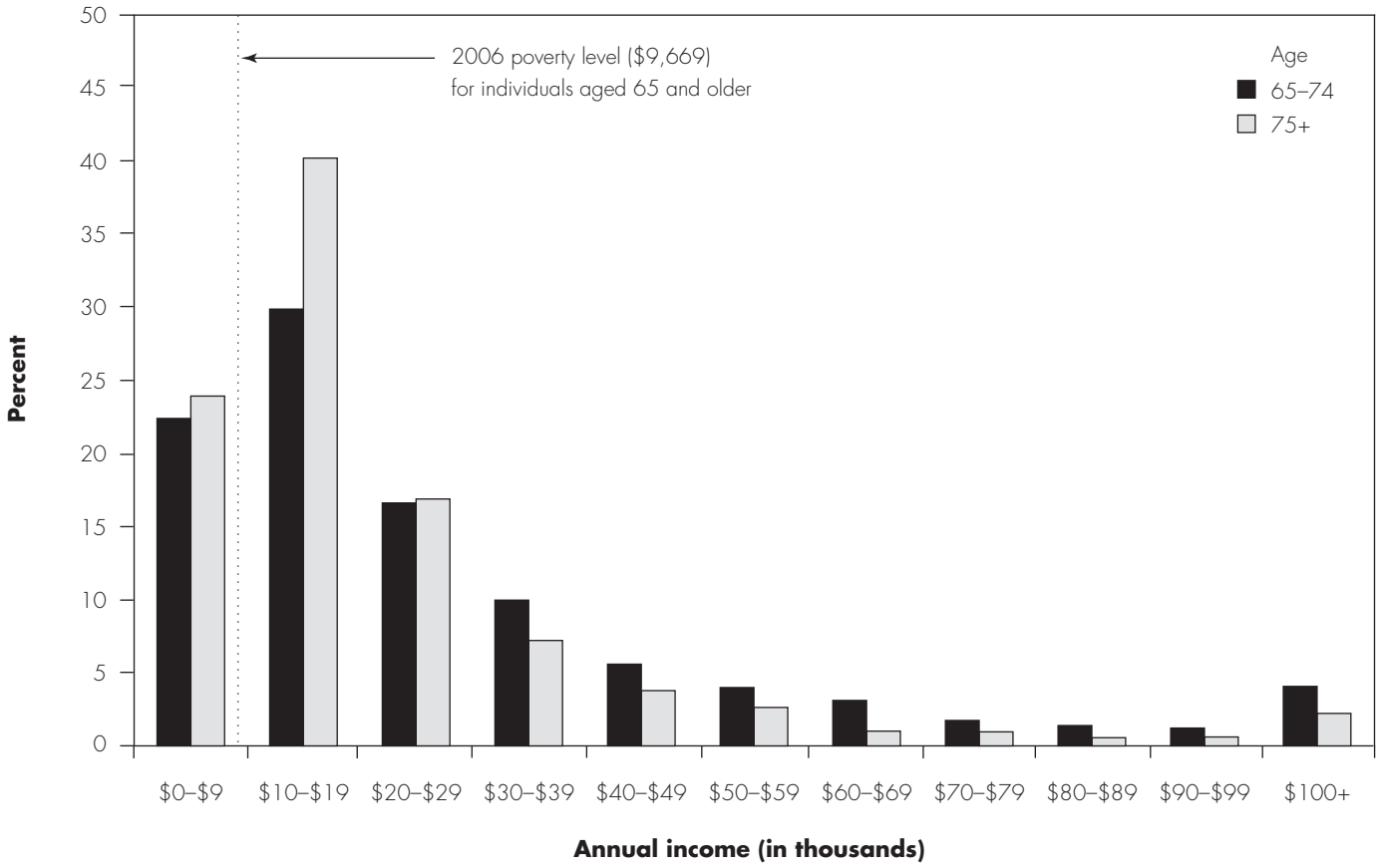
It is difficult to find recent income and out-of-pocket health care spending data on the under-65 disabled Medicare beneficiary population. Researchers using 1998 data found that disabled Medicare beneficiaries were twice as likely as the population 65 or older to have incomes below the poverty line. Disabled beneficiaries with mental impairments were particularly likely to fall below the poverty line (Briesacher et al. 2002).[9]

Out-of-pocket health care spending

The 65-or-older population has higher out-of-pocket health care expenses than those under 65 because of poorer health status and the structure of the Medicare benefit package (MedPAC 2006). In a recent report, researchers quantified this difference in out-of-pocket health care spending by age (Desmond et al. 2007).[10] They found that the median total annual health care expenditure for individuals aged 65 or older was $1,939 in 2003, almost three times as high as the $664 expenditure of their under-65 counterparts. These out-of-pocket health care expenditures represented 12.5 percent of income for the 65-or-older population, compared with 2.2 percent of income for the under-65 population. Even when prescription drug spending was omitted, the population 65 or older had higher out-of-pocket spending than the under-65 population (Figure 5-6, p. 321).

FIGURE 5–4

Within the older population, the oldest have lower incomes



Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement.

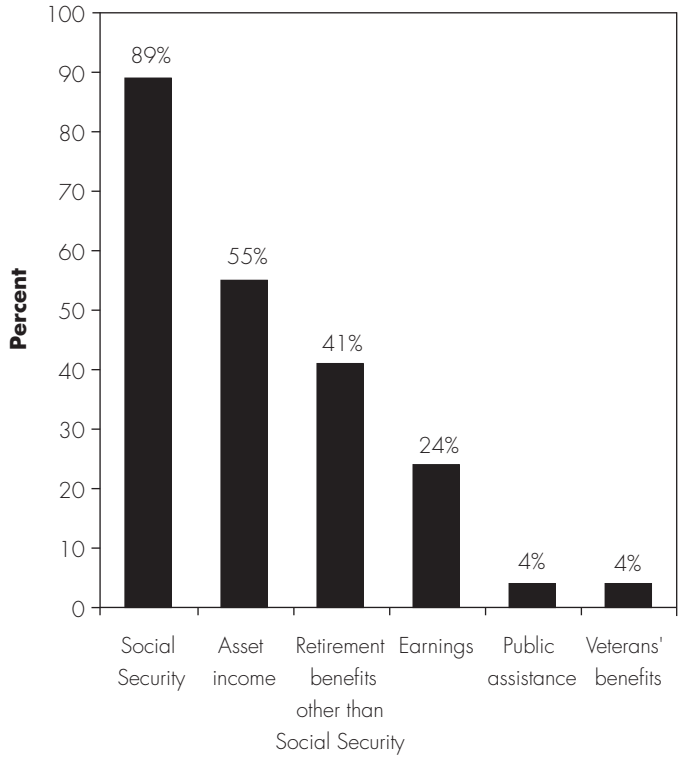
The population 65 or older has out-of-pocket health care expenditures nearly twice as high as their closest age cohort. The population aged 55 to 64 spent a per capita median amount of $843 on out-of-pocket health care expenses in 2002, compared with $1,616 for the population 65 or older (not shown). These out-of-pocket health care expenditures represented a much larger share of total expenditures for the 65-or-older population than for their younger counterparts. Out-of-pocket health care expenditures accounted for 5 percent of total expenditures for the population aged 55 to 64 and 12.3 percent of expenditures for the population aged 65 or older.

Health care avoidance and MSP participation

Because of lower incomes and greater out-of-pocket health care costs, Medicare beneficiaries, particularly those near the poverty line, may avoid necessary health care. MSP enrollees are less likely to forgo treatment. A 2005 study attempted to quantify the extent to which patients avoid health care because of the cost by examining physician visit, hospital visit, and prescription drug avoidance using 2001 self-reported data.[11] Avoidance was determined based on responses to the following questions: (1) Have you gone without getting care from a doctor because it cost too much? (2) Was there a time you thought you needed to be admitted to the hospital but you did not go because you worried about what it would cost you? (3) How many times did you decide not to fill a prescription because it was too expensive? After controlling for demographic differences and health status, QMB enrollees were found to be half as likely as QMB-qualifying nonenrollees to avoid physician visits because of cost. Researchers did not find a significant difference in use

FIGURE 5–5

Social Security is the most common source of income for people 65 and older



Source: Social Security Administration. 2004. *Income of the Aged Chartbook.*

of prescription drugs and hospital visits between the two populations, but non-QMBs were more likely to use the emergency room (Federman et al. 2005).[12]

While the research suggests that MSPs improve access to care, participation rates for eligible beneficiaries are low. The following section describes some of the ways the federal government, states, and community organizations have tried to increase participation.

Efforts to increase program participation

Policymakers, beneficiary advocates, and researchers have suggested a number of strategies to increase participation in the subsidy programs. Strategies can be classified into two categories: improve outreach to increase awareness of the programs and simplify the eligibility, application, and retention procedures. The second strategy includes aligning MSP and LIS requirements so that beneficiaries can apply for both types of aid simultaneously. The federal government, many states, community groups, and health plans have initiated programs that address one or more of these strategies. Most efforts have had a significant but limited impact on program participation. In this section, we draw from some of the more successful campaigns to suggest policy recommendations.

Increasing outreach

Medicare beneficiaries, providers, and even many beneficiary counselors do not know about the availability of MSPs. Medicare beneficiaries, particularly those with limited incomes, are difficult to reach. Beneficiaries who are eligible but not enrolled in MSPs or LIS are more likely to live in rural areas or be homebound, have limited English proficiency, have difficulty seeing or hearing, or have cognitive difficulties. Even the most effective outreach strategies may have only limited success enrolling beneficiaries in the programs. However, federal resources could be more efficiently targeted to reach this population.

CMS (then the Health Care Financing Administration (HCFA)) sponsored an early effort to increase MSP participation. The agency produced and distributed information on the programs and created a task force with state and community activists to promote program participation. It identified increased program enrollment as a goal of the Government Performance Results Act and provided grants to states to increase enrollment (Nemore et al. 2006). The agency's goal was to increase program participation nationally by 4 percent in the first year. As part of the initiative, the agency, in consultation with the states, developed a methodology for measuring baseline enrollment in MSPs (HCFA 1999). Although the goal remains, the agency no longer provides targeted grants for these purposes.

In response to a congressional mandate, SSA notified beneficiaries about their potential eligibility for MSPs in 2002. The Government Accountability Office estimated that the SSA mailings from May through November 2002 to 16.4 million potentially eligible beneficiaries increased enrollment by 74,000 additional beneficiaries (GAO 2004). In the year following the mailings, MSP enrollment increased nationally 2.4 to 2.9 percentage points over the previous three years. In particular, enrollment increased for beneficiaries under age 65, racial and ethnic minorities, and residents in southern states.

The Robert Wood Johnson Foundation and the Commonwealth Fund sponsored an initiative, State Solutions, to increase participation by low-income beneficiaries in MSPs. Beginning in 2002, the foundations gave five states grants of up to $450,000 over a three-year period to boost enrollment.[13] States were required to provide matching support at a 50 percent rate (which could include in-kind contributions and local grant support). The foundations also provided technical assistance. State efforts have included using data from SSA to identify and recruit potential enrollees, contacting participants in other programs that serve similar populations like senior housing projects and food stamp programs, and simplifying processes for participants to apply and renew enrollment in the programs. Over the period of the grant, QMB and SLMB enrollment increased by 45 percent in the five states compared with 22 percent nationally (Fox 2007). Data suggest that the most successful outreach efforts carefully targeted eligible individuals and provided specific information on how and where to get help with the enrollment process (Summer 2006).

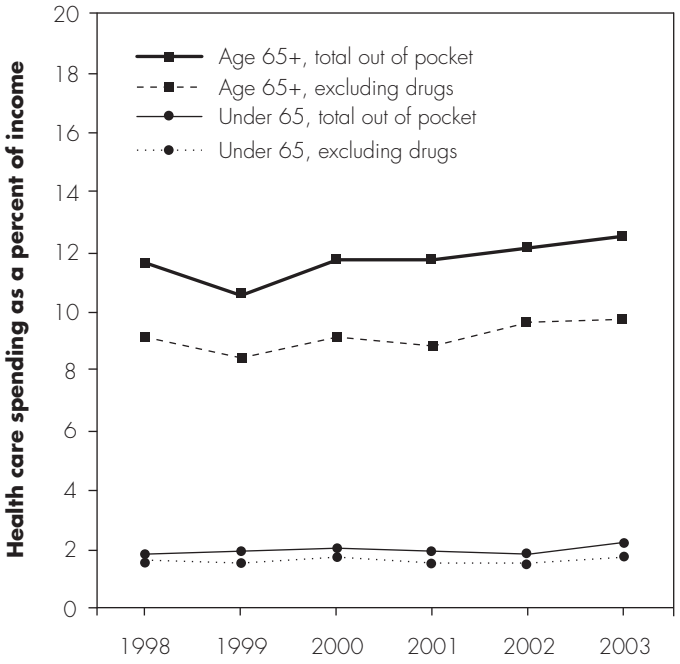
One large health plan, with technical assistance from the National Council on Aging, developed a model to identify plan members who might be eligible for LIS and other benefit programs including MSPs. The targeted population was contacted through mailings and phone calls and advised to contact the plan's LIS call center. Plan members who contacted the center were screened for program eligibility and told where to apply for benefits. As a result of this initiative, almost 11,000 beneficiaries (or 13 percent of plan members contacted) applied for LIS. Of those who applied, about 2,600 (or 25 percent) were eligible and received the subsidy in 2006. In addition, nearly 45 percent were found to be eligible for but not enrolled in Medicaid, Supplemental Security Income (SSI), or MSPs (22 percent, 16 percent, and 7 percent, respectively) (Kiefer et al. 2007).

The National Medicare Education Program

The federal government provides funds for Medicare beneficiary education and counseling through the National Medicare Education Program. The program's funding goes to the *Medicare & You* beneficiary handbook, the 1–800–Medicare call center, the Medicare website, multimedia campaigns, and community-based outreach. More than half the money dedicated to beneficiary education goes to the Medicare call center.

CMS intends the call center to be a single point of contact for all Medicare inquiries, although the center is not equipped to answer questions on LIS or MSPs. The call

FIGURE 5–6 **Older people spend a much higher share of their incomes on health care**



Source: Federman et al. 2005.

system includes an interactive voice response system that can provide information and can also direct calls. In fiscal year 2006, beneficiaries made about 29 million calls to Medicare call centers, an increase of 68 percent in call volume from 2004 at more than double the cost.[14] During this period, caller satisfaction decreased by 13 percentage points to 71 percent of callers who completed their calls. An additional 21 percent of callers hung up before they received answers to their questions (OIG 2007).

Most call center representatives are trained to read prepared scripts with answers to frequently asked Medicare questions. The Office of Inspector General reports that call center staff are not Medicare specialists and sometimes have difficulty understanding questions well enough to find the right script (OIG 2007). They refer questions on LIS to SSA and do not have the state-specific knowledge needed to provide information on MSPs. A modest increase in the call center budget is unlikely to resolve these problems.

While the 1–800–Medicare call center is an important resource, CMS allocates much less funding to sources

that individually counsel beneficiaries. Researchers have emphasized that the Medicare population responds best to personal contacts with trusted sources (Hibbard et al. 2001, 1998). In our previous work on how beneficiaries learned about the Medicare drug benefit, the Commission learned that a relatively small percentage of beneficiaries, or those that helped them, used the Medicare call center (19 percent). Most preferred to get information through personal contact with family, friends, insurance agents, and health care providers (MedPAC 2006).

State Health Insurance Assistance Programs (SHIPs) are the main federal source of individual-level counseling for beneficiaries. SHIPs are state-based organizations that receive federal funds to provide information and counseling to Medicare beneficiaries. Other community-based groups also provide information, particularly about the Medicare drug benefit. These groups include senior centers, retirement communities, and beneficiary advocacy groups. Groups that address the needs of individuals with specific diseases or disabilities also provide counseling.

In 2006, SHIPs received about $30 million from CMS. SHIPs vary in the amount of resources available to them. Most depend on a limited number of paid employees and volunteers. SHIPs could use additional resources to train volunteers and community organizers on the local criteria for MSP eligibility and how to enroll beneficiaries in LIS and MSPs. They could use funds to employ an individual dedicated to resolving Part D or MSP issues. Additional funds would allow SHIPs to increase outreach, education, and counseling efforts to more isolated communities including rural areas, beneficiaries with limited English proficiency, or those with cognitive difficulties. Some SHIPs might use the additional funding to train local SSA workers to screen and enroll beneficiaries in MSPs. Some funding could be used to expand SHIP data collection efforts to allow policymakers to assess the success of various initiatives undertaken to educate and enroll these hard-to-reach populations.

SHIPs could also use some funds to support the work of community-based organizations. For example, they could use the funds to train local volunteers on program eligibility. They could purchase laptop computers so that volunteers could submit applications for eligible beneficiaries from their homes, churches, or other community sites. They could also support funding for written materials and translators to help beneficiaries who are not English speakers.

Programs supported by the State Solutions grants provide examples of successful local outreach programs (Summer 2006):

- Minnesota trained 50 SHIP volunteers to work with Indian Health Service workers to find and enroll eligible Medicare beneficiaries in regions where reservations were located. MSP enrollment in these areas increased by 43 percent in two years.
- State SHIPs worked with managers at senior public housing sites in Pennsylvania and New Hampshire to screen and enroll eligible Medicare beneficiaries in these states. Resident managers at the sites were able to identify potentially eligible applicants and assure residents that the programs were legitimate (Blume 2006).
- Louisiana Medicaid developed partnerships with local representatives at SSA, Meals on Wheels, physicians, pharmacists, and home health providers. Outreach to Medicare beneficiaries was coupled with administrative changes to MSPs and resulted in a 44 percent increase in enrollment (Kennedy 2007).

On our site visit to Maine, beneficiary counselors told us that the most efficient way to target information to homebound and rural beneficiaries was to use local media to inform them about the programs. All messages would include a local number and tell beneficiaries to call for additional information. SHIP counselors could then arrange appointments with callers to screen them for eligibility and help them enroll in appropriate programs.

RECOMMENDATION 5-1

The Secretary should increase State Health Insurance Assistance Program funding for outreach to low-income Medicare beneficiaries.

RATIONALE 5-1

Medicare beneficiaries, particularly those who are hard to reach, get most of their information from personal contact. Beneficiaries who qualify for MSPs need help finding out about the programs and applying for them. Increased funding for groups that provide this expertise and one-on-one counseling will encourage more beneficiaries to enroll in programs for which they are eligible.

IMPLICATIONS 5-1

Spending

- Indeterminate. Program spending would increase based on increased participation in MSPs.

Beneficiaries

- Low-income beneficiaries who enroll in MSPs would save money. Individuals who enroll in the QMB program may also have increased access to medical services.

Simplifying eligibility and enrollment

While it would increase the visibility of the programs, analysts find that more targeted outreach has only a limited effect on participation rates if the application process is too complicated and documentation requirements are too onerous. Researchers have found that beneficiaries are largely unable to apply for MSPs themselves because of the complexity of the application process. More than two-thirds of enrolled individuals had help applying for the programs. States also face high administrative costs processing applications and verifying data. The Congress and the states can make changes to eligibility criteria and enrollment processes for these programs that would simplify enrollment and increase participation. If the Congress aligned income and asset requirements for the MSPs with those that apply to LIS, outreach workers could use one application and screening process for both programs. States could also make changes to their administrative processes that would simplify enrollment for beneficiaries.

As noted on p. 313, the Congress set income and asset criteria for LIS at higher levels than minimum federal MSP criteria, making it easier for beneficiaries to qualify. For example, beneficiaries must have incomes below 135 percent of the poverty level to qualify for the QI program but can have incomes up to 150 percent of the poverty level and qualify for some help under LIS. In addition, the minimum federal resource limit for MSPs ($4,000 for individuals and $6,000 for couples) has not changed since the program was implemented in 1989. Beneficiaries may have assets valued as high as $11,990 for an individual or $23,970 for a couple and still qualify for LIS.

Raising the federal asset limit for MSPs would increase the number of people eligible for the programs but its main effect would be to ease the documentation requirements for beneficiaries and make it simpler for counselors to screen and enroll individuals for both programs simultaneously. Officials in states that have liberalized the asset test have found that the change did not result in large increases in enrollment but did provide administrative cost savings and simplified the enrollment process for beneficiaries (Tiedemann and Fox 2004). (A number of databases are available that permit states to check the accuracy of income data. Information on beneficiary assets is more difficult to examine unless the assets produce income.) In addition, research has found that few beneficiaries who meet the income requirements have significant assets (Rice and Desmond 2006).[15]

States already have considerable flexibility to adjust countable income and resources above federal requirements. For example, eight states have eliminated the asset test for some or all of the MSP programs and others do not consider certain sources of income or resources. Generally, these states have experienced small increases in beneficiary participation and report administrative savings.

In 2001, Arizona Medicaid analyzed the number of beneficiaries who would qualify for MSPs if the state eliminated the asset test. They also studied the cost of verifying assets and the potential administrative cost savings if verification were no longer necessary. They found that 475 applicants would have become eligible for MSPs if assets were not counted. On the other hand, cost savings would result from less postage, fewer forms, and less employee time spent on verifying assets. Overall, analysts found that the state would spend only about $75,000 more annually on MSPs if the asset test were eliminated (Tiedemann and Fox 2004). If the Congress raises the asset limit rather than eliminating it, administrative savings will be lower but alignment with LIS limits will still permit one eligibility determination and enrollment process for both programs.

RECOMMENDATION 5-2

The Congress should raise Medicare Savings Program income and asset criteria to conform to low-income drug subsidy criteria.

RATIONALE 5-2

Federal MSP asset criteria have not been revised since 1989, but many states have chosen to raise income and asset limits to meet the needs of their elderly population. In establishing LIS, the Congress recognized that beneficiaries with incomes below 150 percent of the

poverty level and with limited assets had difficulty meeting their out-of-pocket health care costs. If MSP criteria were aligned with LIS levels, beneficiaries could apply for both programs at one time. Beneficiaries with incomes up to 150 percent of the poverty level would be eligible for QI benefits. Beneficiaries would find the process simpler and state and federal governments would realize administrative savings.

IMPLICATIONS 5-2

Spending

- If the QI program is reauthorized, as we expect, this recommendation would increase spending between $250 and $750 million for one year and between $1 and $5 billion over five years.[16]

Beneficiaries

- Low-income beneficiaries who enroll in MSPs would save money. Individuals who enroll in the QMB program may also have increased access to medical services.

This recommendation mainly affects federal spending. Income eligibility for QMBs and SLMBs would remain the same—the increased income limit of 150 percent of the poverty level affects only the fully federal QI program. The asset limit for QMBs and SLMBs would increase modestly, while the asset limit for QIs would increase more substantially. In addition, the federal government currently is responsible for more than half the cost of QMB and SLMB benefits under Medicaid, with the federal match rate varying from 50 percent to 76 percent of the cost.

SSA and MSPs

SSA is responsible for determining LIS eligibility for those individuals who are not deemed eligible for the subsidy. Beneficiaries can apply for LIS without facing the possible stigma associated with applying at a state Medicaid office. If MSP and LIS eligibility were based on the same criteria, SSA could screen and enroll beneficiaries for both programs simultaneously. Under current law, states must screen beneficiaries for both programs if they apply at a Medicaid office, but SSA does not have this requirement.

SSA has experience determining eligibility for aged and disabled Medicare recipients who qualify for Medicaid. Currently, 32 states and the District of Columbia contract with SSA to determine Medicaid eligibility for SSI beneficiaries (Ebeler et al. 2006). In those states, the SSI application is also the Medicaid application and Medicaid eligibility starts the same month as SSI eligibility. SSA notifies the state through a computer network called the State Data Exchange System. The state sends the Medicaid card to the individual based on the computer file information from SSA.[17] By law, states that contract with SSA for this purpose pay SSA one-half the cost of carrying out the agreement, including only costs that are additional to determining SSI eligibility.[18] By law, SSA cannot use money from the Social Security trust funds to administer programs outside their core mission.

RECOMMENDATION 5-3

The Congress should change program requirements so that the Social Security Administration screens low-income drug subsidy applicants for federal Medicare Savings Program eligibility and enrolls them if they qualify.

RATIONALE 5-3

This recommendation would simplify application and enrollment for beneficiaries. Administrators could use a single application for MSP and LIS eligibility. Since LIS participation is higher than MSP rates, it would increase participation in the program by eligible beneficiaries who have not heard of it. If income and asset requirements were the same for both programs, SSA workload would not increase substantially. However, administrative funding for SSA has not kept pace with the work level. For example, SSA is currently facing a record high backlog of disability claims. As of October 2007, roughly 758,000 disability claims cases were awaiting a hearing or an appealed claim. This is almost double the caseload in 2001. We recognize that the agency would need more resources to implement this recommendation.

IMPLICATIONS 5-3

Spending

- We do not have a separate estimate for this recommendation. The Commission believes the cost is largely included within Recommendation 5-2. Program spending would increase based on increased participation in MSPs.

Beneficiaries

- Low-income beneficiaries who enroll in MSP would save money. Individuals who enroll in the QMB program may also have increased access to medical services.

State actions to simplify application and enrollment

States can take additional steps to simplify application and enrollment processes for MSPs. In general, state efforts to increase participation in these programs have varied. Officials have had to balance their desire to provide more assistance to their residents with limited incomes with the need to balance their budgets in an era of increasing Medicaid expenditures. Responses have differed significantly. For example, states' administrative processes vary. Some require beneficiaries to apply for MSPs at the state Medicaid office while others permit mail-in applications, an easier method for beneficiaries. Similarly, some states require original documents to support applications while others permit beneficiaries to submit copies. Some states have simplified their application forms while others have not. Federal law requires states to facilitate MSP enrollment by instituting processes to ensure that a resident who applies for one type of assistance is screened for all types of assistance for which the person may be eligible, but advocates indicate that this rule is not always followed.

With the help of a grant from the State Solutions Project, Louisiana Medicaid has been particularly active in efforts to increase participation in MSPs through administrative simplification. For example, the state simplified the application form, permitted mail-in applications, reduced requirements for verification of assets, and used less restrictive requirements for countable assets (Kennedy 2007).[19]

Louisiana policymakers also simplified the annual renewal process. Noting that the income of low-income beneficiaries rarely changes much annually, the state began conducting renewals through use of online data collected for other programs like the food stamp program. Beneficiaries were contacted only if this type of review was not possible. Administrative costs to the state fell from $31.73 for a full renewal to $9.84 for this abbreviated process. Savings resulted from reduced personnel, postage, and printing costs (Summer 2004). As a result of all the state's efforts, enrollment in MSPs increased from about 97,000 in 2001 to 137,000 in 2005, a nearly 41 percent increase (Sofaer 2006).

In mid-2007, the state further simplified the renewal process by adopting the procedure used by SSA for LIS. The state currently sends letters to enrollees providing previous state data on income and assets for the individual and directs beneficiaries to contact the program only if the information is no longer correct. If beneficiaries do not contact the Medicaid office, their enrollment is renewed (Kennedy 2007). (The state can still check the accuracy of the data through online databases.)

Incentives for states to promote increased MSP participation

States that provide additional drug coverage to beneficiaries have greater incentives to enroll residents in MSPs. At least 42 states have established or authorized some type of program to provide pharmaceutical coverage or assistance. Programs include those that provide wraparound coverage for Part D, those that provide discounts, and others that support drugs that are not covered by Part D. The wraparound subsidy programs (State Pharmacy Assistance Programs (SPAPs)) use state funds to pay for a portion of the costs, usually for a defined population that meets enrollment criteria. As of July 2007, 29 states had programs in operation. Since MSP enrollees are deemed eligible for LIS, the state can increase the number of SPAP members with LIS by enrolling more people in MSPs. Because LIS is federally funded, states with SPAPs save money because the federal drug subsidy covers most beneficiary cost sharing and gap coverage that the state would otherwise pay. In addition, if beneficiaries qualify for the QI program, the federal government finances all covered benefits.

Some states with SPAPs have changed their eligibility and enrollment procedures to increase MSP enrollment. For example, Vermont and Maine eliminated the asset test for MSP applicants (see text box, pp. 315–317). States have also improved their information management systems to allow them to verify beneficiary financial eligibility information through existing databases (e.g., check food stamp records or tax records to verify income). Some states have developed electronic record systems that can be accessed remotely. Thus, eligibility workers can use laptop computers to make eligibility determinations at SSA offices or other community locations.

Five states increased MSP enrollment by more than 50 percent in 2006: Vermont, Montana, Illinois, Maine, and New York.[20] All these states offer SPAPs to qualified residents but researchers cannot prove a causal relationship between the existence of SPAPs and the expansion of MSP enrollment (Reinhard 2007).

States may have additional incentives to increase MSP participation. Some policymakers have suggested that state Medicaid programs can save money by increasing

TABLE 5–3 **Most MSP participants receive full Medicaid benefits, 2004**

Beneficiary category	Number of eligibles	Percent
Full benefit and meeting MSP limits (QMB Plus)	4,756,000	80%
Meet MSP but do not qualify for full benefits (QMB Only, SLMB, QI)	1,166,000	20
Total	5,922,000	100

Note: MSP (Medicare Savings Program), QMB (Qualified Medicare Beneficiary), SLMB (Specified Low-income Medicare Beneficiary), QI (Qualifying Individual).

Source: Medicaid Statistical Information System, 2004.

enrollment in MSPs and LIS. Beneficiaries receiving these benefits may be less likely to spend down to full Medicaid eligibility (Chandler 2007, Fox and Gray 2007).

Policymakers interested in expanding MSP participation have access to a body of research on state and local organization strategies to increase enrollment in MSPs and other programs designed for individuals with limited incomes (see, e.g., ABC 2007, 2006; Ebeler et al. 2006; Sofaer 2006; Summer 2006). States could increase MSP participation rates if they adopted some of these practices.

Federalizing MSP

The Commission recognizes that Medicaid spending for individuals dually eligible for Medicare and Medicaid accounts for a significant share of state Medicaid budgets. Dual eligibles make up about 14 percent of Medicaid enrollment but account for 40 percent of all Medicaid expenditures for medical services (Holahan and Ghosh 2005). While about two-thirds of Medicaid spending for this population covers the cost of long-term care (a benefit not covered under Medicare), Medicaid payments for Medicare premiums, deductibles, and coinsurance for Medicare-covered services amounted to an additional $16.7 billion or 16 percent of Medicaid spending for dual eligibles in 2003 (Holahan and Ghosh 2005).[21] State expenditures for dual eligibles vary based on state eligibility, benefit package, and payment policy; the number of dual eligibles in the state; and the federal matching rate.

Having the federal government assume the full costs of all care (including long-term care) for individuals dually eligible for Medicare and Medicaid, as it has under the LIS program, might be the most efficient policy approach. However, the Medicare program is not financially sustainable and such a broad program expansion would make the situation worse. Although still costly, federalizing MSPs is a more incremental strategy—individuals participating in the programs are Medicare beneficiaries receiving assistance with Medicare premiums and coinsurance. If MSPs were federalized, federal funds would cover the Part B premiums for QMBs and SLMBs as well as the deductibles and coinsurance for Medicare-covered services for QMBs.[22]

However, before the Congress decided to federalize MSPs, it would have to resolve significant issues of equity among states and beneficiaries. Unlike the recommendations in this chapter that focus on how to increase participation in the current programs, federalizing MSPs mostly involves Medicare buying out the cost of a benefit currently paid by Medicaid. Since states have different eligibility and payment rules, a single federal standard would produce winners and losers. In other words, some states gain and some lose, and some beneficiaries within states gain and some lose.

Currently, states have considerable flexibility to determine eligibility for Medicaid and MSPs. As a result, beneficiaries in some states receive full Medicaid coverage, while others with the same level of income and assets are eligible only for MSP benefits or for no benefits at all. For example, some states provide full Medicaid benefits to beneficiaries with incomes below 100 percent of the poverty level while others do not. Depending on how federal criteria are applied, states that provide more generous benefits to beneficiaries could receive less financial savings from federalization than those that provide fewer benefits to beneficiaries with limited incomes. Additionally, some states use income and asset levels that are higher than federal MSP criteria. If all beneficiaries had to meet federal standards, some individuals who currently qualify for MSPs in their states could lose both MSP and LIS benefits unless the state chose to cover them with state-only funds.[23]

To address these issues, policymakers would have to answer a number of design questions:

- Which of the eligibility groups that receive MSP benefits would be covered by full federal funding?

- What set of rules would govern program eligibility—that is, a national standard or a higher level chosen by the state?
- Would Medicare assume all coinsurance for QMBs?
- Would states be required to maintain a level of effort?

Which of the eligibility groups that receive MSP benefits would be covered by full federal funding?

MSPs currently consist of three programs: QMB, SLMB, and QI. QMB is by far the largest of the programs. Under current law, QMBs are individuals who are entitled to Medicare Part A, have incomes that do not exceed the federal poverty level, and have resources that do not exceed twice the eligibility limit for SSI. Within the QMB category, Medicare distinguishes two groups. Individuals who are not otherwise eligible for Medicaid but meet the QMB criteria are defined as QMB Only. The discussion in this paper generally applies to beneficiaries in this group. A larger group of beneficiaries (80 percent of all MSP enrollees) meet the QMB criteria but are also eligible for full Medicaid benefits in their state (Table 5-3). CMS refers to this group as QMB Plus. Medicaid pays MSP benefits for all QMBs.

Under current law, QMB eligibility varies by state. In any state, beneficiaries with a given level of income and assets may be QMB Plus and in another state they may be QMB Only. If policymakers decided to federalize MSP benefits, they would need to determine whether the policy applied to all QMB enrollees or to those designated QMB Only.

In about one-third of states, Medicare beneficiaries with incomes below 100 percent of the poverty level who meet the asset test receive full Medicaid benefits, including long-term care benefits. In other states, individuals with the same income and assets would be QMB Only. If federalization applied to the QMB Only population, states that provide more generous benefits to their beneficiaries (by making them QMB Plus) would receive less savings from federalization than states that limit QMB Plus benefits to fewer individuals. Federalization to QMB Only beneficiaries could lead states to switch some beneficiaries from QMB Plus to QMB Only. If a state no longer provided full Medicaid benefits to this population, it would receive more federal payments but beneficiaries with limited incomes would lose benefits.

If federalization applied to all QMBs, most of whom are QMB Plus, the federal cost would be significantly higher since the program would cover many more people. States would realize considerable savings. They would still need to provide non-Medicare benefits like nursing home and dental care to beneficiaries receiving full Medicaid coverage.

What set of rules would govern program eligibility?

As noted earlier, some states disregard higher levels of beneficiary income or assets when determining MSP eligibility. If federalization applied to all beneficiaries currently eligible for MSPs, eligibility for the programs would continue to vary by state, albeit with the federal government paying the full cost. If states were not permitted to use flexible eligibility standards, some individuals who currently receive benefits would no longer be eligible unless states chose to cover them with state-only funds. Those who received LIS because they were enrolled in MSPs could also lose eligibility for the drug subsidy since they would no longer be deemed eligible.

Policymakers would also have to decide how the program would be administered. Eligibility determination might follow the model adopted for LIS. People could apply at SSA offices for MSP assistance only or they could apply through the state Medicaid agency; those choosing the latter course would also be screened for full-benefit eligibility. As in Recommendation 5-3, SSA would need increased resources if this approach were adopted but the amount of funds required would be higher.

Would Medicare assume all coinsurance for QMBs?

The Part B premium is set nationally but cost sharing for Medicare-covered services (a benefit received by QMBs) is determined by the Medicaid state plan. The Balanced Budget Act of 1997 clarified that states could limit cost-sharing payments for Medicare-covered services to the lesser of the difference between the Medicare payment and the maximum the state would have paid for the same service under Medicaid. Medicaid payment rates vary by setting, by service, and by state but most states do not pay the full Medicare cost sharing for all services. Providers must accept the Medicaid payment as payment in full. If cost sharing for QMBs were federalized, Medicare would likely set payment levels nationally. The federal government could pay the full cost-sharing amount, which would further increase the cost of federalization. Alternatively, it could pay a fixed percentage of the cost-sharing amount. For example, instead of paying 20 percent

coinsurance for Part B services, Medicare could pay 15 percent.

Would states be required to maintain a level of effort?

To estimate the cost of federalizing MSP benefits within the context of the Commission's three recommendations, we made two assumptions: Federalization would include all QMBs and Medicare would pay full cost sharing for Medicare-covered services. Under these assumptions, we estimate that the cost of MSP federalization would fall into the Commission's highest financial impact category, which is greater than $2 billion for one year and greater than $10 billion for five years.

As with the Part D benefit, the Congress could reduce the federal cost by requiring states to maintain a level of effort. This policy would again raise issues of equity among states. In general, states that currently have high per capita costs for MSP benefits have more generous eligibility requirements, higher provider payment rates, and a lower federal match. For example, Minnesota permits beneficiaries to retain more assets than under the federal LIS standard. It pays full Medicare coinsurance for QMBs and has a 50 percent federal match, the lowest possible matching rate. If MSPs were federalized using one national standard, the state would likely pay one of the highest maintenance-of-effort rates. Further, the state might have to use state-only funds to continue covering beneficiaries eligible under their current asset test.

The Commission concludes that the three recommendations in this chapter can increase participation in MSPs and LIS at a modest federal cost. They are designed to relieve beneficiaries with limited incomes of the increasing cost of the Part B premium and some of the high out-of-pocket health care costs they face. Yet, even with these recommendations, some beneficiaries will have difficulty with cost sharing, particularly those with high use of medical services. Medicare does not include catastrophic protection. As a longer term project, we plan to examine the benefit design of the program. ■

Endnotes

1 For discussion of barriers to enrollment, see Ebeler and colleagues (2006) and Nemore and colleagues (2006).

2 Data are limited on the assets of beneficiaries with low incomes, so all counts of the eligible population are estimates. For example, the Congressional Budget Office estimates that 14.2 million beneficiaries were eligible for LIS in 2006, while CMS placed the number at 13.2 million.

3 An estimated 2.4 million Medicare beneficiaries would have qualified based on income but were turned down for LIS because their assets exceeded the eligibility standards.

4 Additional cash savings of up to $1,500 per person are permitted if the individual intends to use the money for burial expenses.

5 Because Maine uses beneficiary-centered assignment to place its DEL and Medicaid enrollees in plans that officials believe best suit their needs, the state was the authorized representative of the enrollees. Thus, the state could enroll residents in the programs without having to contact them.

6 CMS required that the increase for all MSP categories be equal in value. Therefore, to increase the former QI limit to 185 percent of the federal poverty level to match the DEL income limits, the limits for the other MSPs also had to increase by 50 percent.

7 As with other Medicaid services, QMB and SLMB benefits are financed by state and matching federal funds. The QI program is federally funded.

8 Since the beginning of the Medicaid program in 1965, states have been permitted to recover the costs of benefits received from the estates of deceased Medicaid recipients who were over age 65 when they received benefits and who had no surviving spouse, minor child, or adult disabled child.

9 Researchers used data from the 1998 Medicare Current Beneficiary Survey.

10 Researchers used Consumer Expenditure Survey data from 1998 to 2003 to compare the ratio of out-of-pocket health care spending with self-reported annual pretax dollar income among Medicare eligibles with the ratio among people under age 65. Out-of-pocket health care spending included premiums for private insurance and Medicare Part B, medical services and supplies, and prescription drugs.

11 Federman and colleagues (2005) used the 2001 study of seniors' prescription coverage, use, and spending to compare self-reported avoidance of health care due to costs between QMB-Only enrollees and QMB-qualifying nonenrollees.

12 Note that neither population received prescription drug coverage from Medicare or Medicaid during this period.

13 Louisiana, Minnesota, New Hampshire, New York, and Pennsylvania received awards from the project.

14 The implementation of Part D and the expansion of MA were largely responsible for the increased volume of calls.

15 The most common assets are bank accounts and life insurance policies.

16 The majority of this cost is the extension of the QI program under current law, estimated at $300 million annually.

17 Seven additional states use SSI criteria to determine Medicaid eligibility but the beneficiary must make a separate application to the state for Medicaid benefits. SSA refers these individuals to the state Medicaid agency but estimates that from 10 percent to 20 percent never file an application (Cusick and Nibali 2005).

18 Section 1634(a) of the Social Security Act: The Commissioner of Social Security may enter into an agreement with any State which wishes to do so under which the Commissioner will determine eligibility for medical assistance in the case of aged, blind, or disabled individuals under such State's plan approved under title XIX. Any such agreement shall provide for payments by the State, for use by the Commissioner of Social Security in carrying out the agreement, of an amount equal to one-half of the cost of carrying out the agreement, but in computing such cost with respect to individuals eligible for benefits under this title, the Commissioner of Social Security shall include only those costs which are additional to the costs incurred in carrying out this title.

19 Many other states have developed applications that permit beneficiaries to "self-declare" their income or asset data while the state uses data match systems to verify the figures. Examples include Arizona, Arkansas, Connecticut, Hawaii, Minnesota, North Dakota, Rhode Island, Texas, Vermont, and Washington (Tiedemann and Fox 2004).

20 Overall, MSP enrollment in the six states increased by 170,000 during 2006 (Reinhard 2007).

21 State payments for full dual eligibles account for the vast majority of these costs.

22 QIs are fully federally funded.

23 Any beneficiary enrolled in MSPs is automatically eligible for LIS without regard to income or assets.

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